



Enrollment Assessment Residential Treatment

► Enrollment Date: / /
mm dd yyyy

► ESM Client ID:

Provider ID:

Questions (Q) marked with ► must be completed.

Boxes marked with ★ = Refer to Key at end of form

First Name:		Middle Initial:	Last Name:	Suffix:
► 1. Client Code: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		► 2. Intake/Clinician Initials: <input type="text"/> <input type="text"/> <input type="text"/>		
► 3. Do you own or rent a house, apartment, or room? <input type="checkbox"/> Yes <input type="checkbox"/> No If the answer to Q. 3 is Yes, skip to Q. 5				
4. Are you Chronically Homeless? (HUD Definition in Manual) <input type="checkbox"/> Yes <input type="checkbox"/> No		► 5. ZIP Code of Last Permanent Address: Do Not put zip code of Program. See manual for definition of Permanent.		
► 6. Where did you stay last night?				
1 <input type="checkbox"/> Emergency shelter	7 <input type="checkbox"/> Jail, prison or juvenile detention facility	13 <input type="checkbox"/> Foster care home or foster care group hm		
2 <input type="checkbox"/> Transitional housing for homeless persons	8 <input type="checkbox"/> Room, apartment, or house that you own or rent	14 <input type="checkbox"/> Place not meant for habitation		
3 <input type="checkbox"/> Permanent housing for formerly homeless	9 <input type="checkbox"/> Staying or living with a family member	15 <input type="checkbox"/> Other		
4 <input type="checkbox"/> Psychiatric hospital or other psych. facility	10 <input type="checkbox"/> Staying or living with a friend	88 <input type="checkbox"/> Refused		
5 <input type="checkbox"/> Substance abuse treatment facility or detox	11 <input type="checkbox"/> Room, apartment, or house to which you cannot return (future return can be uncertain)			
6 <input type="checkbox"/> Hospital (non-psychiatric)	12 <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher			
► 7a. Do you consider yourself to be transgender? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused				
7b. If you answered Yes to Q. 7a, please specify: <input type="checkbox"/> Male to Female <input type="checkbox"/> Female to Male <input type="checkbox"/> Other, specify _____				
► 8. Do you consider yourself to be: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Gay/Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Refused				
► 9. Number of days between initial contact with program by client or someone on behalf of client and the first available opening (bed) : (unknown = 999) See manual to help determine wait time. <input type="text"/>				
► 10. Source of Referral: <input type="text"/> <input type="text"/> ★				
► 11. Frequency of attendance at self-help programs (e.g. AA, NA) in 30 days prior to Admission: <input type="text"/> <input type="text"/> ★				
► 12. Client Type <input type="checkbox"/> Primary <input type="checkbox"/> Collateral				
13. Additional Client Type (Check ALL that apply)				
New <input type="checkbox"/> Student	<input type="checkbox"/> Postpartum	<input type="checkbox"/> Methadone	New <input type="checkbox"/> Injectable Naltrexone (e.g. Vivitrol)	<input type="checkbox"/> Parole <input type="checkbox"/> Federal Parole
<input type="checkbox"/> Pregnant	Change <input type="checkbox"/> Veteran/ Any Military Service	Change <input type="checkbox"/> Buprenorphine (e.g. Suboxone)	<input type="checkbox"/> Probation	<input type="checkbox"/> Federal Probation
► 14. Do you have children? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused If answer to Q. 14 is 'Yes', complete 14a-14d. If no, skip to Q. 15				
14a. Number Children Under 6: <input type="text"/>		14b. Number of Children 6-18: <input type="text"/>		14c. Children Over 18: <input type="text"/>
14d. Are any of the children of the Native American Indian race? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
► 15. Are you the primary caregiver for any children? 🚩 If yes, see manual. If the client is the primary caregiver of children, you must assess as to the children's welfare and what arrangements have been made for their care in your full clinical assessment!!! <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused				
► 16. Employment status at Enrollment: <input type="text"/> ★		► 17. Number of days worked in the past 30 days? <input type="text"/>		
► 18. Where do you usually live? (Where has the client spent/slept most of the time over the last 12 months?)				
1 <input type="checkbox"/> House or apartment	3 <input type="checkbox"/> Institution	5 <input type="checkbox"/> Shelter/mission	7 <input type="checkbox"/> Foster Care	88 <input type="checkbox"/> Refused
2 <input type="checkbox"/> Room/boarding or sober house	4 <input type="checkbox"/> Group home/treatment	6 <input type="checkbox"/> On the streets	8 <input type="checkbox"/> N/A Infant	
► 19. Who do you live with? (Check all that apply) COLLATERAL CLIENTS STOP AFTER THIS QUESTION				
<input type="checkbox"/> Alone	<input type="checkbox"/> Child 6-18	<input type="checkbox"/> Spouse/Equivalent	<input type="checkbox"/> Other Relative	
<input type="checkbox"/> Child under 6	<input type="checkbox"/> Child over 18	<input type="checkbox"/> Parents	<input type="checkbox"/> Roommate/Friend	

▶ 20. Use of mobility aid: (Check all that apply)		<input type="checkbox"/> None		<input type="checkbox"/> Crutches		<input type="checkbox"/> Walker		<input type="checkbox"/> Manual Wheelchair		<input type="checkbox"/> Electric Wheelchair	
▶ 21. Vision Impairment <input type="checkbox"/> *		▶ 22. Hearing Impairment <input type="checkbox"/> *		▶ 23. SelfCare/ADL Impairment <input type="checkbox"/> *		▶ 24. Developmental Disability <input type="checkbox"/> *					
▶ 25. Prior Mental Health Treatment:		0 <input type="checkbox"/> No history		1 <input type="checkbox"/> Counseling		2 <input type="checkbox"/> One hospitalization		3 <input type="checkbox"/> More than one hospitalization			
▶ 26. During the past 12 months, did you take any prescription medication that was prescribed for you to treat a mental or emotional condition?		1 <input type="checkbox"/> Yes		2 <input type="checkbox"/> No		88 <input type="checkbox"/> Refused		99 <input type="checkbox"/> Unknown			
▶ 27. Number of prior admissions to each substance abuse treatment modality (0 - 5 admissions, '5' = 5 or more, 99=unknown) Do not count this tx. episode.											
<input type="text"/> Detox		<input type="text"/> Outpatient		<input type="text"/> Drunk Driver		<input type="text"/> Other					
<input type="text"/> Residential		<input type="text"/> Opioid		<input type="text"/> Section 35							
▶ 28. Currently receiving services from a state agency: (Check all that apply)											
<input type="checkbox"/> None		<input type="checkbox"/> DMH does client have a case mgr.?		<input type="checkbox"/> DTA e.g. food stamps		<input type="checkbox"/> MCDHH MA Comm. Deaf					
<input type="checkbox"/> DCF was DSS		<input type="checkbox"/> DDS was DMR		<input type="checkbox"/> MRC Mass Rehab Comm		<input type="checkbox"/> Other					
<input type="checkbox"/> DYS youth services		<input type="checkbox"/> DPH e.g. HIV/STD; not BSAS tx..		<input type="checkbox"/> MCB Commission for Blind		See manual for system generated associations (e.g. Client Type Probation – OCP services.)					
▶ 29. Number of arrests in the past 30 days?		<input type="text"/>		(Section 35 is not an arrest, it is a civil commitment)							
▶ 30. History Substance Mis-use, Nicotine/Tobacco Use & Gambling											
For pharmaceutical drugs prescribed for the client, only code misuse (more than the recommended dosage) or non-medical use. (Example - If the client was prescribed a benzodiazepine for a mental health disorder and used per instruction, do not list on History Table.) Note: For the safety of the client all drugs used must be recorded in the client record.(See Manual for commercial names.)											
				Have You Ever Mis-Used/Bet		Age of First Use/Bet	Last Use/Bet	Freq of Last Use/Bet	Route of Admin Code		
				Y N							
A	Alcohol			For Alcohol, enter first age of intoxication							
B	Cocaine										
C	Crack										
D	Marijuana / Hashish										
E	Heroin										
F	Prescribed Opiates			Misuse/non-medical use of pharmaceutical opiates which were prescribed for the client.							
G	Non-prescribed Opiates			Non-medical use of pharmaceutical opiates which were not prescribed for the client							
H	PCP										
I	Other Hallucinogens										
J	Methamphetamine										
K	Other Amphetamines										
L	Other Stimulants										
M	Benzodiazepines										
N	Other Tranquillizers										
O	Barbiturates										
P	Other Sedatives / Hypnotics										
Q	Inhalants										
R	Over the Counter										
S	Club Drugs										
U	Other										
X	Nicotine/Tobacco			Includes cigarettes, cigars, chewing tobacco, inhalers							
Y	Gambling			Includes any of the types listed in Q.32a							N/A

31a. Number of cigarettes *currently* smokes per day (Indicate number of cigarettes, not number of packs: 1 pack = 20 cigarettes)

If client uses another type of nicotine/tobacco product, mark Zero (0) and go to Q 31b.

If client does not have a history of nicotine/tobacco use, skip Qs 31a & b and go to Q 32a.

31b. Interest in stopping nicotine/tobacco use at Enrollment:

1 ☐ No

3 ☐ Yes, Within 30 days

88 ☐ Refused

2 ☐ Yes, Within 6 Months

4 ☐ Does Not Apply (already stopped)

99 ☐ Unknown

32a. Types of last regular gambling (*check all that apply*) If person does not have a gambling history, skip Q. 32 and go to Q. 33.

☐ Lottery - Scratch Tickets

☐ Slot Machines

☐ Sports Betting

☐ Stock Market

☐ Lottery - Keno

☐ Casino Games

☐ Bingo

☐ Internet Gambling

☐ Lottery/Numbers Games

☐ Card Games

☐ Dog/Horse Tracks, Jai Alai

32b. Have you ever thought you might have a gambling problem, or been told you might? ☐ Yes ☐ No ☐ Refused

Nicotine/Tobacco and Gambling CANNOT be marked as a primary/secondary/or tertiary drug. This applies for Substances A through U Only.

IT IS VITAL THAT PATIENTS BE ASKED IF THEY HAVE a SECONDARY and/or TERTIARY DRUG OF CHOICE. Clinicians may rank substances based on their clinical opinion after review of the substance use history and not necessarily client report.

▶ 33. Rank substances by entering corresponding letter for substances listed above in Question 30. (If no secondary or tertiary substance, leave blank)

Primary Substance

Secondary Substance

Tertiary Substance

▶ 34. Needle Use?

0 ☐ Never

1 ☐ 12 or more months ago

2 ☐ 3 to 11 months ago

3 ☐ 1 to 2 months ago

4 ☐ Past 30 days

5 ☐ Last week

▶ 35a. How many overdoses have you had in your lifetime:

▶ 35b. How many overdoses have you had in past year?

Massachusetts Residential Recovery Program - Enrollment Patient Placement Criteria

► Section 1: Acute Intoxication and/or Withdrawal Potential

Any "yes" response indicates that the client is not acutely intoxicated or at risk for physical withdrawal at the point of admission. Any "no" response indicates that the client is acutely intoxicated or at risk of a physical withdrawal at the point of discharge and indicates the need of a more intensive level of care. **The client is not at risk of physical withdrawal as evidenced by AT LEAST ONE of the following:**

	YES	NO	N/A
1a. Clean Urine Screens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1b. Stable Vital Signs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1c. Verification of detoxification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1d. Staff Observation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1e. Self report of no recent drug/alcohol abuse:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

► Section 2: Biomedical Stabilization

A "yes" response is based on a program's determination that the client is medically stable enough to participate in what the program considers to be its most "essential components."

	YES	NO	Unknown
2a. The client's biomedical conditions, if any, are sufficiently stable as evidenced by the ability to participate in the essential components of a residential substance abuse program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2b. The client is demonstrating responsibility in matters of personal health care and is complying with the course(s) of treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behaviors consistent with biomedical stabilization may include the following outcome measures:			
*2-1. Client has a primary care clinician	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

► Section 3: Behavioral Stabilization

A "yes" response in this dimension indicates the need for the client to be in a Residential Recovery Program.

	YES	NO	N/A
3a. The client's behavioral conditions, if present, are sufficiently stable to prevent behaviors which put themselves or others at risk.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3b. The client is sufficiently oriented so that s/he comprehends and understands the materials presented during the intake/screening process, AND can fully participate in the residential treatment process	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behaviors consistent with behavioral stabilization may include the following outcome measures:			
*3-1. Client currently abstains from illicit and non-prescribed drugs/alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*3-2. Client currently abstains from illegal behavior (not including drug use)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*3-3. Client currently addressing pending legal issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*3-4. Client currently addressing outstanding debts and/or financial obligations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

► Section 4: Treatment Acceptance/Resistance

Any "no" response in this section indicates that the client does not accept treatment..

	YES	NO	N/A
4a. The client agrees to abstain from alcohol and/or non-prescribed psychoactive substances as evidenced by a willingness to contract to follow the rules and policies of the program, AND	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4b. The client agrees to participate in an environment that promotes recovery through peer interaction, counseling and educational forums.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

► **Section 5: Relapse Potential**

Any "yes" response indicates significant risk for substance abuse relapse and the need for a structured residential setting. The client's relapse potential is significant outside the residential setting as evidenced by ONE OR MORE of the following:.

	YES	NO	N/A
5a. Lack of awareness of relapse triggers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5b. Ambivalence towards treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5c. Difficulty postponing immediate gratification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5d. Preoccupation with alcohol and other drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5e. History of multiple treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5f. History of relapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5g. Lack of membership in 12 step or other self-help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

► **Section 6: Recovery Environment**

Any "yes" response in this dimension indicates the need for the client to be in the safe recovery environment of a Residential Recovery Program.

	YES	NO	N/A
6a. Client has engaged in behavior or occupation in which recovery is unlikely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6b. Recovery is jeopardized by lack of social and sober contacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behaviors consistent with the development of a support network may include one or more of the following:			
*6b-1. Involvement in the 12-step community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*6b-2. Involvement in Smart Recovery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*6b-3. Involvement in women for sobriety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*6b-4. Involvement in other self help	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*6b-5. Support of family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*6b-6. Involvement with religious/spiritual/faith activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6c. Client lives in an environment that is a threat to the attainment of abstinence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

► **Section 7: Diagnostic Criteria**

The client is assessed as meeting the diagnostic criteria for a Psychoactive Substance Use Disorder as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM) or other standardized, widely accepted criteria.

	YES	NO	N/A
7a. The individual is assessed with an alcohol and/or other drug abuse and/or dependency disorder based on established diagnostic criteria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

★ Q10. Source of Referral at Enrollment					
Code		Code		Code	
01	Self, Family, Non-medical Professional	20	<i>Change</i> Health Care Professional, Hospital	67	Department of Corrections
02	BMC Central Intake/Room 5	21	Emergency Room	68	Office of the Commissioner of Probation
03	ATS/Detox	22	HIV/AIDS Programs	69	Massachusetts Parole Board
04	Transitional Support Services/TSS	23	Needle Exchange Programs	70	Dept. of Youth Services
05	Clinical Stabilization Services/CSS-CMID		<i>24 through 25 Discontinued</i>	71	Dept. of Children and Families
06	Residential Treatment	26	<i>New</i> Mental Health Professional	72	Dept. of Mental Health
07	Outpatient SA Counseling		<i>27 through 29 Discontinued</i>	73	Dept. of Developmental Services
08	Opioid Treatment	30	School Personnel, School System/Colleges		<i>74 through 76 Discontinued</i>
09	Drunk Driving Program	31	<i>New</i> Recovery High School	77	Mass. Rehab. Commission
10	Acupuncture		<i>31 through 39 Discontinued</i>	78	Mass. Commission for the Blind
11	Gambling Program	40	Supervisor/Employee Counselor	79	Mass. Comm. For Deaf & Hard of Hearing
	Note: Sec 35 Options are grouped although numbers are not in sequence. Select correct #				
			41 through 49 Discontinued	80	Other State Agency
12	Sec 35 (WATC & MATC)	50	Shelter	81	Discontinued
24	Sec 35 Bridgewater MASAC	51	Community or Religious Organization		
25	Sec 35 Framingham MCI		<i>52 through 58 Discontinued</i>	99	Unknown
	<i>13 Discontinued</i>	59	Drug Court		
14	Sober House	60	Court - Section 35		
16	<i>New</i> Recovery Support Centers		<i>61 & 62 Discontinued</i>		
15	Information and Referral	63	Court - Other		
17	Second Offender Aftercare	64	Prerelease, Legal Aid, Police		
18	Family Intervention Program	65	County House of Corrections/Jail		
19	Other Substance Abuse Treatment	66	Office of Community Corrections		

★ Q 11 Frequency of Attendance at Self-Help Programs			
Code		Code	
01	No attendance in the past month	05	16-30 times in past month (4 or more times per week)
02	1-3 times in past month (less than once per week)	06	Some attendance, but frequency unknown
03	4-7 times in past month (about once per week)	99	Unknown
04	8-15 times in past month (2 or 3 times per week)		

★ Q 16 Employment Status at Enrollment					
Code		Code		Code	
1	Working Full Time	6	Not In Labor Force - Retired	11	Volunteer
2	Working Part Time	7	Not In Labor Force - Disabled	12	Other
3	Unemployed - Looking	8	Not In Labor Force - Homemaker	13	Maternity/Family Leave
4	Unemployed - Not Looking	9	Not In Labor Force - Other	99	Unknown
5	Not In Labor Force - Student	10	Not In Labor Force - Incarcerated		

Code	★ Q. 21 Vision Impairment
0	None: Normal Vision
1	Slight: vision can be or is corrected with glasses/lenses
2	Moderate: "Legally blind" but having some minimal vision
3	Severe: No usable vision

Code	★ Q. 22 Hearing Impairment
0	None: Normal hearing requiring no correction
1	Slight: Hearing is or can be adequately corrected with amplification (eg hearing aid)
2	Moderate: Hard of hearing, even with amplification
3	Severe: Profound deafness

Code	★ Q 23 Self Care/ADL Impairment
0	None: No problem accomplishing ADL skills such as bathing, dressing and other self-care
1	Slight: Uses adaptive device(s) and/or takes additional time to accomplish ADL but does not require attendant
2	Moderate: Needs personal attendant up to 20 hours a week for ADL
3	Severe: Requires personal attendant for over 20 hours a week for ADL

Code	★ Q. 24 Developmental Disability
0	None
1	Slight Developmental Disability
2	Moderate Developmental Disability
3	Severe Developmental Disability

★ Q 30: SUBSTANCE MIS-USE / NICOTINE/TOBACCO / GAMBLING HISTORY							
Code	Last Use Substances		Code	Frequency of Last Use/bet		Code	Route of Administration
1	12 or more months ago		1	Less than once a month		1	Oral (swallow and/or chewing)
2	3-11 months ago		2	1-3 times a month		2	Smoking
3	1-2 months ago		3	1-2 times a week		3	Inhalation
4	Past 30 days		4	3-6 times a week		4	Injection
5	Used in last week		5	Daily		5	Other
			99	Unknown			